SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Filing at a Glance

Company: Sun Life Assurance Company of Canada

Product Name: Group Stop Loss	SERFF Tr Num: SNLF-126122890	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 42459
Sub-TOI: H21.000 Health - Other	Co Tr Num: 2009 CONTRACT REVISIONS	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Linda Murphy, James Crowley, Frank Jancura, Lori Chilcote	Disposition Date: 06/02/2009
	Date Submitted: 05/22/2009	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: 2009 Contract Revisions	Status of Filing in Domicile: Authorized
Project Number:	Date Approved in Domicile: 04/02/2009
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer, Other
Filing Status Changed: 06/02/2009	Explanation for Other Group Market Type: Union
	State Status Changed: 06/02/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

RE: Sun Life Assurance Company of Canada

NAIC #80802 FEIN 38-1082080

Stop Loss Policy Insert Forms 07-SL-ELIG rev. et al

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Form Number Description
07-SL- ELIG rev. Expenses Eligible for Reimbursement
07-SL-MEDTRAVEL Medical Travel Benefit
07-SL-CT rev. Clinical Trials
07-SL-LAE rev. Limitations and Exclusions
07-SL- CLAIM rev. Claim Provisions
07-SL-GP rev. General Provisions
07-SL-SUNEXCEL rev. Transplant Benefit
XGR/2748 Application Form

Dear Commissioner:

The above forms are being submitted for your review and approval. They are new forms and do not replace any forms previously approved by your department.

These additional insert pages provide additional options and some revisions to aggregate and specific stop loss coverage to employers who self fund their employees' health benefit plan. The employer is reimbursed for expenses paid on behalf of its employees and their dependents.

When approved, we will be these forms with previously approved policy form 07-SL et al.

These forms were approved in our domiciliary state (Michigan) on April 2, 2009.

The minimum specific attachment point will meet any applicable state minimum requirements, and the minimum aggregate attachment point will meet any applicable state minimum requirements.

The filing does not contain any unusual or potentially controversial items from normal entity or industry standards.

Variables in the policy are indicated by brackets. The variable items may or may not be printed, or may change, depending on the context in which they appear.

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

These forms will not be mass marketed or solicited by mail. The forms will be marketed on a general basis by our group sales representatives, and will be marketed to employer groups, union groups and other types of group allowed by the laws of your state.

The forms submitted:

• are in final print form, subject only to minor variations in color, paper stock, duplexing, shading, fonts and positioning; and

• meet the requirements of the Flesch Readability Test. Enclosed is a certification signed by an officer of our company.

Should you have any questions regarding this filing, please do not hesitate to contact me; my telephone number and email address are shown below.

Sincerely,

James Crowley
Compliance Consultant
Telephone: 1-860-737-1310
Email: james.crowley@sunlife.com

Company and Contact

Filing Contact Information

James Crowley, Compliance Consultant
175 Addison Road
Windsor, CT 06095-0725

James.Crowley@sunlife.com
(800) 451-2513 [Phone]
(860) 737-6598[FAX]

Filing Company Information

Sun Life Assurance Company of Canada
175 Addison Road
Windsor, CT 06095
(860) 737-1000 ext. [Phone]

CoCode: 80802
Group Code: 549
Group Name:
FEIN Number: 38-1082080

State of Domicile: Michigan
Company Type:
State ID Number:

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$160.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sun Life Assurance Company of Canada	$160.00	05/22/2009	28060196

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/02/2009	06/02/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	05/29/2009	05/29/2009	James Crowley	05/29/2009	05/29/2009

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Disposition

Disposition Date: 06/02/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Medical Travel Benefit	Approved-Closed	Yes
Form	Clinical Trials Benefit	Approved-Closed	Yes
Form	Expenses Eligible for Reimbursement	Approved-Closed	Yes
Form	Limitations and Exclusions	Approved-Closed	Yes
Form	Claim Provisions	Approved-Closed	Yes
Form	General Provisions	Approved-Closed	Yes
Form	Transplant Benefit	Approved-Closed	Yes
Form *(revised)*	Group Application	Approved-Closed	Yes
Form	Group Application	Replaced	Yes

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
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TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/29/2009
Submitted Date	05/29/2009
Respond By Date	

Dear James Crowley,

This will acknowledge receipt of the captioned filing.

Objection 1

- Group Application (Form)

Comment:

The application must contain the notice which is outlined under our Bulletin 6-2008.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/29/2009
Submitted Date	05/29/2009

Dear Rosalind Minor,

Comments:

Response 1

Comments: Per your comment, attached please find a revised application which contains the notice required in Bulletin 6-2008. The required notice can be found on page 4, just below the signature line.

Related Objection 1

Applies To:

- Group Application (Form)

Comment:

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

The application must contain the notice which is outlined under our Bulletin 6-2008.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Group Application	XGR/2748		Application/Enrollment Form	Initial		51	XGR-2748 _AR_.pdf
Previous Version							
Group Application	*XGR/2748*		*Application/Enrollment Form*	*Initial*		*51*	XGR-2748.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Frank Jancura, James Crowley, Linda Murphy, Lori Chilcote

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	07-SL-MEDTRAVEL	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Medical Travel Benefit	Initial		52	07-SL-MEDTRAVEL.pdf
Approved-Closed	07-SL-CT rev.	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Clinical Trials Benefit	Initial		53	07-SL-CT rev1.pdf
Approved-Closed	07-SL-ELIG rev.	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Expenses Eligible for Reimbursement	Initial		52	07-SL-ELIG rev1.pdf
Approved-Closed	07-SL-LAE rev.	Policy/Contract/Fraternal Certificate: Amendmen	Limitations and Exclusions	Initial		53	07-SL-LAE rev1.pdf

SERFF Tracking Number:	*SNLF-126122890*		*State:*	*Arkansas*		
Filing Company:	*Sun Life Assurance Company of Canada*		*State Tracking Number:*	*42459*		
Company Tracking Number:	*2009 CONTRACT REVISIONS*					
TOI:	*H21 Health - Other*		*Sub-TOI:*	*H21.000 Health - Other*		
Product Name:	*Group Stop Loss*					
Project Name/Number:	*2009 Contract Revisions/*					
		t, Insert Page, Endorsement or Rider				
Approved-Closed	07-SL-CLAIM rev.	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Claim Provisions	Initial	52	07-SL-CLAIM rev1.pdf
Approved-Closed	07-SL-GP rev.	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	General Provisions	Initial	52	07-SL-GP rev1.pdf
Approved-Closed	07-SL-SUNEXCEL rev.	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Transplant Benefit	Initial	53	07-SL-SUNEXCEL rev1.pdf
Approved-Closed	XGR/2748	Application/Enrollment Form	Group Application	Initial	51	XGR-2748 _AR_.pdf

Section II
Benefit Provision

[MEDICAL TRAVEL BENEFITS

Introduction

The Medical Travel Benefit Provision provides reimbursement for:

- Eligible Expenses incurred by a Covered Person for Treatment received outside of the United States;
- Medical Travel access fees, if such fees are covered under Your Plan;
- Travel, lodging and meal expenses incurred by a Covered Person (and the Covered Person's parents or legal guardian(s) if the Covered Person is a minor or one companion if the Covered Person is not a minor) in connection with the Medical Travel, if such expenses are covered under Your Plan; and
- Certain expenses and deductibles paid by the Covered Person for which Your Plan has reimbursed the Covered Person.

Definitions

Medical Travel: The travel by a Covered Person outside of the United States to obtain medical treatment from a doctor, hospital or healthcare provider.

Requirements

To receive reimbursement under the Medical Travel Benefit Provision all of the following criteria must be satisfied:

1. Your Plan must cover Treatment received by a Covered Person outside of the United States;
2. The Covered Person's Medical Travel must be provided by and arranged through a vendor approved by Us (the "Medical Travel Vendor").
3. You must demonstrate: (a) that Your Plan has paid for the Covered Person's Medical Travel and the Treatment provided in connection with it; and (b) that the Treatment has been provided to the Covered Person.
4. The expenses resulting from the Treatment provide in connection with the Medical Travel must be Eligible Expenses.

Eligible Expenses will also include the following fees paid by Your Plan in connection with a Covered Person's Medical Travel and the Treatment provided in connection with it:

1. Up to [$500-$10,000] for travel, lodging and meal expenses incurred by the Covered Person (and the Covered Person's parents or legal guardian(s) if the Covered Person is a minor or one companion if the Covered Person is not a minor) in connection with the Medical Travel if the Medical Travel was arranged by the Medical Travel Vendor;

2. Up to [$500-$5,000] for any deductible or co-payment Your Plan has reimbursed the Covered Person where the deductible or co-payment related to the Treatment for which the Medical Travel was undertaken.

3. Up to [$100-$5,000] for Medical Travel access fees.

Section II
Benefit Provision

For the purpose of this Medical Travel Benefit Provision only, the Limitation and Exclusion that provides that: "Expenses for any Treatment administered outside the United States if the Covered Person traveled to the location where the Treatment was received for the purpose of obtaining the Treatment" is hereby deleted. That Limitation and Exclusion shall continue to apply to any claim that does not fall under this Medical Travel Benefit Provision. All other Limitations and Exclusions set forth in the Policy shall remain in force and apply to this Medical Travel Benefit Provision.

[This Medical Travel Benefit Provision shall not provide coverage for any Transplant received by a Covered Person outside of the United States.]]

Section II
Benefit Provisions
[Clinical Trials Benefit Provision

[The Clinical Trials Benefit Provision is added for the purpose of determining whether expenses incurred by a Covered Person resulting from his or her participation in a Phase II or III clinical trial ("Clinical Trial Expenses") are Eligible Expenses.

For expenses submitted for reimbursement under the Policy other than Clinical Trial Expenses, all Policy provisions shall apply as if this provision did not exist.

Pursuant to this provision, Eligible Expenses will include Clinical Trial Expenses when:

(a) You provide Us with:

1. A copy of the clinical trial treatment protocol from the facility that conducted the clinical trial; and
2. A copy of the Covered Person's signed consent and authorization to participate in the clinical trial; and

(b) You provide documentation that demonstrates to Our satisfaction that:

1. The Treatment was provided as part of an ongoing Phase II or III clinical trial sponsored by the National Cancer Institute, National Institute of Health or the FDA; and
2. The Treatment provided by the clinical trial is covered by Your Plan; and
3. Funding is not available for the routine costs of the clinical trial from the National Cancer Institute, the National Institute of Health, the FDA or any other entity. "Routine costs" shall have the meaning attributed to it by the Centers for Medicare and Medicaid Services in its Coverage Issues Manual for clinical trials; and

The clinical trial has been approved by an institutional review board. An "institutional review board" shall mean a committee of physicians, statisticians, researchers, community advocates and others that ensures that a clinical trial is ethical and that the rights of trial participants are protected; and

(c) We obtain a determination by an Independent Review Panel, in which a majority of the panel agrees and represents to Us, that the Treatment provided to the Covered Person as part of the clinical trial constitutes the standard of care for the treatment of the Covered Person's medical condition.

The decision to require a determination from an Independent Review Panel shall be at our discretion. If we decide that a determination from an Independent Review Panel is necessary, we shall be responsible for obtaining it and will pay the cost of it.

This provision shall apply only to Clinical Trial Expenses for Treatment Incurred by a Covered Person after the effective date of this provision. This provision shall not apply to Clinical Trial Expenses for Treatment Incurred by a Covered Person if the Covered Person: (a) is enrolled in; (b) has been evaluated for participation in; (c) has signed a consent form for; or (d) has been recommended to participate in a Phase II or III clinical trial prior to the Effective Date of this provision.]

Section II
Benefit Provisions
Expenses Eligible for Reimbursement

Eligible Expenses
Eligible Expenses include any amount paid by You for Medically Necessary and Appropriate expenses incurred by a Covered Person which:

1. Have been paid in accordance with the terms of Your Plan; and
2. Were Incurred and Paid during the applicable claims basis; and
3. Are paid under a Covered Benefit shown on the Schedule of Benefits; and
4. Are not otherwise excluded under this Policy.

Alternative Care
In addition to satisfying Eligible Expenses criteria 2,3 and 4 above, expenses related to Alternative Care may be considered Eligible Expenses when all of the following additional criteria have been satisfied and submitted to Sun Life Case Management for approval:

1. You demonstrate to Our satisfaction that providing the Alternative Care resulted in a cost savings to the Plan; and
2. The Alternative Care was recommended by case management services provided to Your Plan; and
3. The Alternative Care was Medically Necessary and Appropriate; and
4. The Alternative Care was provided with the consent of the Covered Person, or his/her representative, and with the approval of the Covered Person's licensed health care provider, and was approved by You or Your TPA; and
5. The Alternative Care replaces Treatment that would be covered under Your Plan; and
6. The Alternative Care expenses do not exceed the maximum allowed under Your Plan for the Treatment replaced by the Alternative Care; and
7. If the Alternative Care is provided in lieu of inpatient hospitalization, the Covered Person meets utilization review criteria acceptable to Us for inpatient hospitalization for the entire period the Alternative Care is provided. In no event will such Alternative Care that exceeds 90 days be considered Eligible Expenses unless approved by Us.

Off-Label Drug Use
In addition to satisfying the criteria for Eligible Expenses set forth above, expenses related to Off-Label Drug Use may be considered Eligible Expenses when all of the following additional criteria have been satisfied:

1. The drug is not excluded under Your Plan; and
2. The drug has been approved by the FDA; and
3. You can demonstrate to Our satisfaction that the Off-Label Drug Use is appropriate and generally accepted for the condition being treated; and
4. If the drug is used for the treatment of cancer, Lexi-Comp with AHFS-DI (American Hospital Formulary Service Drug Information), Micromedex Drugpoints, NCCN (National Comprehensive Cancer Network) Drugs and Biologics Compendia, or Wolters Kluwer Health Facts and Comparisons, recognize it as an appropriate treatment for that form of cancer.
5. The drug is not provided as part of a Phase I, II or III clinical trial as defined by the National Institute of Health, National Cancer Institute or the FDA.

Reimbursement of Certain Fees
Eligible Expenses will also include the following fees Incurred and Paid by You, when approved by Us at Our U.S. Headquarters:

Reasonable hourly fees for case management services provided by a registered nurse case manager retained by You or Your TPA; and

Fees for: (a) hospital bill audits; (b) access to non-directed provider networks; and (c) negotiating out of network bills.

Such fees shall be considered Eligible Expenses only if You can demonstrate to Us that the work that generated the fees resulted in a cost savings to the Plan. If the Plan can demonstrate such a cost savings, We will reimburse You up to [25%] of the amount saved.][, up to a maximum of [$5,000] per hospital confinement per Covered Person.]

Fees charged by Your TPA or any subsidiary of Your TPA for any of these services will be considered Eligible Expenses only if prior approval has been obtained in writing from Us at Our U.S. Headquarters.

State Health Care Surcharges

If You pay a state health care surcharge in connection with the payment of Eligible Expenses, the health care surcharge shall be considered an Eligible Expense. Penalties or fines associated with the health care surcharge or the underlying expenses will not be considered Eligible Expenses.

Section II
Benefit Provisions
Limitations and Exclusions

We will NOT reimburse You for:

1. [Expenses for medical services rendered to a Covered Person by the Covered Person's family member or relative.]
2. [Expenses that are payable or reimbursable under any Workers' Compensation Law or similar legislation.]
3. [Expenses for any cosmetic Treatment as defined in Your Plan. This exclusion does not apply to expenses relating to breast reconstruction after mastectomy.]
4. [Expenses for any Experimental or Investigational Treatment, or for any hospital confinement or Treatment that results from Experimental or Investigational Treatment.]
5. [Expenses for any transplant not included in the definition of Transplant.]
6. [Expenses relating to non-human organ or tissue transplants, gene therapies, xenographs or cloning.]
7. [Expenses for any Treatment administered outside the [United States] if the Covered Person traveled to the location where the Treatment was received for the purpose of obtaining the Treatment.]
8. [Expenses for benefits in excess of Your Plan's limits, or expenses that are excluded under Your Plan.]
9. [Expenses in excess of the Usual and Customary Charge.]
10. [Any amount paid by You in excess of a negotiated provider discount, or any penalty or late charge incurred, or any discount lost, unless previously approved in writing by Us at Our U.S. Headquarters.]
11. [Expenses associated with the administration of Your Plan including, but not limited to, claim payment fees, cost containment administrative fees, PDP administration fees, PPO access fees, premium functions, medical review and consultant fees, unless otherwise covered under this Policy.]
12. [Expenses paid by You relating to any litigation concerning Your Plan, including, but not limited to, attorneys' fees, extra-contractual damages, compensatory damages and punitive damages.]
13. [Any portion of an expense which You are not obligated to pay under Your Plan, or which is reimbursable to You under:
    a) Another group health benefit program; or
    b) A government or privately supported medical research program; or
    c) Medicare; or
    d) Any coordination of benefits or non-duplication of benefits provision of Your Plan; or
    e) Worker's compensation; or
    f) Any other source.]
14. [Expenses incurred by a person who is employed by You at any unit, subsidiary or division of Yours that has not been underwritten by Us.]
15. [Expenses incurred for any illness or injury due to, or aggravated by, war or an act of war, whether declared or undeclared.]
16. [Expenses paid by You for any Treatment authorized or approved under any provision of Your Plan which:
    a) Allows the plan administrator to approve alternative care or alternative treatment; or
    b) Allows the plan administrator to alter, modify, or waive Plan provisions or limitations, or
    c) Grants You or Your plan administrator discretion to approve coverage for Treatment not otherwise covered under Your Plan;

    unless the Treatment satisfies the criteria for Alternative Care set forth in Section II.]

Section II
Benefit Provisions
Limitations and Exclusions

17. [Expenses for any Transplant if You have a separate insurance policy that covers Transplants for Covered Persons regardless of whether the Covered Person is covered by that policy.]
18. [Expenses covered under a Prescription Drug Plan, unless Prescription Drug Plan coverage is a Covered Benefit on the Schedule of Benefits.]
19. [Expenses for Treatment of Mental Illness and Drug or Alcohol Dependence will be limited to the lesser of Your Plan's maximum benefit for such condition or the Specific Benefit Deductible.]
20. [Expenses incurred for any illness or injury due to or aggravated by:
    a) [The Covered Person's operation of any motorized vehicle while Intoxicated. "Intoxicated" means the person operating the motorized vehicle has a blood alcohol level that equals or exceeds the minimum blood alcohol level required to be considered operating a motorized vehicle under the influence of alcohol in the jurisdiction where the accident occurred. "Motorized vehicle" includes, but is not limited to, automobiles, motorcycles, boats and snowmobiles.]
    b) [The Covered Person's committing or attempting to commit an assault, felony or other criminal act; or]
    c) [The Covered Person's voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, unless used on the advice of a physician.]
20. [Notwithstanding any other Policy provision, We will not reimburse any expense incurred by any employee, or by the employee's dependents, where the employee is a member of: (a) a division, unit, group, subsidiary, affiliate, or class of employee of the Policyholder; or (b) an association, trust, cooperative or similar organization connected with the Policyholder, that is not covered by the Plan as of the Policy Renewal Effective Date.]
21. [Regardless of any provision in Your Plan, if on the Policy Effective Date or Policy Renewal Effective Date, a Covered Person is not Actively At Work or a Dependent is totally disabled, is in an institution receiving medical care or Treatment, or is confined at home or elsewhere, any expenses Incurred by the Covered Person or Dependent will not be considered for Eligible Expenses under this policy. This limitation will continue for all expenses Incurred by the Covered Person until he or she is Actively at Work and for all expenses incurred by the Dependent until he or she is no longer totally disabled or is no longer in an institution receiving medical care or Treatment or confined at home or elsewhere.
22. [Expenses relating to an injury or illness arising out of, or occurring during the course of, a Covered Person performing any occupation for wage or profit.]

    For the purpose of this provision:

    a) A Covered Person is considered to be Actively At Work if he or she is:

        i) Working at Your usual place of business or at such place or places that Your normal course of business may require;

        ii) Performing all of the duties of his or her occupation on a full-time basis; and

        iii) Not confined in any institution providing care or treatment of physical or mental infirmities.

    If a Covered Person is not Actively At Work on the Policy Effective Date or Policy Renewal Effective Date solely because that day is not a regularly scheduled workday, the Covered Person will be deemed Actively At Work on that day.

    b) A Dependent is considered totally disabled if he or she, solely because of injury or sickness, cannot engage in substantially all of the normal activities of a person of like age and sex in good health.]**]**

Section III
Claim Provisions

Proof of Claim
Proof of claim must be provided to Us at Our U.S. Headquarters. Expenses for claims submitted to Us that are not submitted in accordance with the Proof of Claim provisions of this Policy are not reimbursable and shall not be considered Eligible Expenses under the Policy.

[Specific Benefit

Written proof of claim, in a form and content satisfactory to Us, must be provided to Us as soon as reasonably possible after the Specific Benefit Deductible for a Covered Person has been satisfied. Proof of claim must be provided to Us [no later than 12 months] after the end of the Specific Benefit Claims Basis during which the claim arose.

Proof of claim for a Specific Benefit claim shall include the following:

1. [A fully completed claim form;]
2. [A copy of the Covered Person's original enrollment record and records of any change in the Covered Person's coverage under Your Plan;]
3. [Copies of all bills [over $25,000] and invoices for expenses submitted for reimbursement under this Policy;]
4. Proof of payment of any expenses submitted to Us for reimbursement under this Policy or a claims paid detailed report, which includes: Dates of Service, Provider Name, Provider TIN, Amount billed, Discount amount, Eligible Amount, Amount paid, Date paid, Reimbursement amount requested, Previously paid amount, ICD 9 codes and CBT Codes; and
5. Any additional information We may require to fulfill Our obligations under this Policy.]

[Aggregate Benefit

Written proof of claim, in a form and content satisfactory to Us, must be provided to Us as soon as reasonably possible after the end of the Aggregate Benefit Claims Basis for the Policy Year. Proof of claim must be provided to Us [no later than twelve (12) months] after the end of the Aggregate Benefit Claims Basis.

Proof of claim for an Aggregate Benefit claim shall include the following:

1. A complete aggregate calculation report;
2. A detailed claims history report for all Eligible Expenses Incurred and Paid during the Aggregate Benefit Claims Basis;
3. A report listing all Covered Units eligible for benefits under Your Plan at any time during the Aggregate Benefit Claims Basis;
4. A copy of Your Plan in effect during the Policy Year and any amendments thereto;
5. If Prescription Drug Plan coverage is included as a Covered Benefit on the Schedule of Benefits, a copy of all prescription drug invoices and an itemization thereof, including the amounts of any rebates received by You; and
6. Any additional information We may require to fulfill Our obligations under this Policy.]

Appeal of a Claim Determination
You may appeal the initial claim determination made by Us under this Policy by submitting a written appeal to Us at Our U.S. Headquarters within sixty (60) days from the date of Our determination. Your appeal should state the basis of Your disagreement with Our initial claim determination and should include all documentation and information supporting Your appeal that has not been previously provided to Us. Once you receive a determination from Us regarding Your appeal, You will have exhausted Your administrative remedies under this Policy.

Deferred Payments by You
You must obtain prior written approval from Us at Our U.S. Headquarters in order for any Eligible Expenses Incurred in the Policy Year, but Paid after the end of the applicable claims basis to be considered eligible for reimbursement under this Policy.

Section III
Claim Provisions

Payment of Claims
All benefits due under this Policy will be paid to You. During the Policy Year, reimbursements will be disbursed when the amount payable exceeds $500.00. Any reimbursable amount remaining unpaid at the end of a Policy Year will be paid after the end of the Policy Year.

Section VI
General Provisions

Assignment
Your interest in this Policy cannot be assigned.

Bankruptcy or Insolvency
The bankruptcy, insolvency, dissolution, receivership or liquidation of You, Your Plan or Your TPA will not impose upon Us any obligations other than those set forth in this Policy.

Clerical Error
In the event of a clerical error in this Policy, the Policy will be revised to correct the error. Your failure to:

1. Report the existence of a Covered Person; or
2. File proof of claim in a timely manner; or
3. Comply with the reporting requirements of this Policy;

shall not constitute clerical error.

Entire Contract
This Policy, along with any Attachments, Riders, Endorsements, Addenda or Amendments, and the Application and Special Risk Questionnaire completed by You constitutes the entire contract of insurance between us.

Legal Action
You may not bring a legal action against Us to recover on this Policy earlier than [sixty (60)] days after You have furnished Us with proof of claim in accordance with the Proof of Claim provisions of this Policy. You may not bring any legal action against Us to recover on this Policy after [two (2)] years from the time proof of claim is required under this Policy.

Misrepresentation
If:

1. You make any misstatement, omission or misrepresentation, whether intentional or unintentional, in the information or documentation You, Your TPA or any other party acting on Your behalf, provide to Us, and which We rely upon during the underwriting of this Policy; or
2. After this Policy is issued, We learn of expenses or claims that were incurred or paid, but not reported to Us, during the underwriting of this Policy,

We have the right, at Our election, to rescind this Policy or to revise the premium rates, deductibles, and terms and conditions of this Policy in accordance with Our underwriting practices in effect at the time the Policy was underwritten. Any such revisions may be made retroactive to the Policy Effective Date.

No ERISA Liability
Under no circumstance will We accept responsibility as a “Plan Administrator” or be deemed a “plan fiduciary” with respect to your Plan under the Employee Retirement Income Security Act of 1974, as amended.

Non-Participating Policy
This Policy is non-participating and does not share in Our surplus earnings.

Policy Amendment
No change in this Policy, or waiver of any of its provisions, will be valid unless such change or waiver is in writing and agreed to by Us at Our U.S. Headquarters and made a part of this Policy. No agent, broker, TPA, or managing general underwriter has authority to change this Policy or waive any of its provisions.

Section VI
General Provisions

Policy Renewal
This Policy may be renewed unless it has been terminated or is subject to termination in accordance with the Termination Provisions of this Policy. Policy changes for any renewal policy will appear on a revised Schedule of Benefits and/or a Policy amendment. Your payment of the renewal premium after receipt of the revised Schedule of Benefits and/or Policy amendment constitutes acceptance of the renewal policy by You.

[No New Special Conditions Rider at Renewal
We guarantee that if You renew Your Policy with Us, Your renewal stop loss policy will not contain a new or revised Special Conditions Rider, provided that:

1. Your Plan contains no changes that materially affect or alter the risk presented by Your current Policy;
2. Your renewal stop loss policy contains no material changes from Your present Policy; and
3. A new unit, division, subsidiary, affiliated company or class of covered people is not added to this Policy.

We reserve the right to carry over to the renewal stop loss policy any Special Conditions Rider that is part of Your current Policy.

We, in our sole discretion, shall determine whether any of the changes referenced in sections 1 through 3 above are material. If We determine that any change is material, this provision shall be of no force and effect.]

[**Special Conditions Rider at Renewal**
If You renew Your Policy with Us, Your renewal stop loss policy may contain a new or revised Special Conditions Rider.]

[**Renewal Rate Increase Cap**
If You renew Your Policy with Us**,** We guarantee that the Specific Benefit Premium Rate [and the Aggregating Specific Deductible] on Your renewal stop loss policy will not be increased more than [50]% over the Specific Benefit Premium Rate [and the Aggregating Specific Deductible] shown on the Schedule of Benefits, provided that:

1. Your Plan contains no changes that materially affect or alter the risk presented by Your current Policy;
2. Your renewal stop loss policy contains no material changes from Your present Policy; including, but not limited to, changes to: a) the length of the Policy Year; (b) Covered Benefits; (c) coverage for Retirees; (d) the Specific Benefit Deductible; (e) the Claims Basis; (f) the Specific Benefit Lifetime Maximum Eligible Expensed; (g) the Specific Benefit Reimbursement Percentage; (h) the commission payable; (i) Your TPA; or (j) Provider Networks;
3. There are no material changes in the demographic distribution of the group covered by Your current Policy versus the group covered by the renewal stop loss policy; and
4. A new unit, division, subsidiary, affiliated company or class of covered people is not added to this Policy.
5. There is no change in any assessment levied against Us by the state in which this Policy was issued.

We, in our sole discretion, shall determine whether any of the changes referenced in sections 1 through 3 above are material. If We determine that any change is material, we shall adjust the Renewal Rate Increase Cap accordingly.]

Section VI
General Provisions

Premium Provisions

Premium Payments

Premium is due on or before the Premium Due Date.

Grace Period

A grace period of [forty-five (45)] days will be allowed for the payment of each premium due after the first premium has been paid. This Policy will continue in force during the grace period. If a premium is not paid by the end of the Grace Period, this Policy will terminate, without notice to You, as of the last date for which premium was paid.

Premium Data

You must provide a report to Us with each premium payment, in a form satisfactory to Us, that lists:

1. The number of each type of Covered Unit, for each Covered Benefit, under Your Plan on the first day of the Benefit Month; and
2. The amount of premium paid.

We use such premium data reports solely to process premium. They do not replace any report required, or which may be required, under Section IV of this Policy.

Severability

In the event that a court of competent jurisdiction invalidates any provision of this Policy, all remaining provisions of the Policy shall continue in full force and effect.

Termination Provisions

1. If You fail to pay the premium, this Policy will terminate in accordance with the Premium Provision of this Policy;
2. If Your Plan is terminated, this Policy will terminate on the date the Plan terminated; or
3. If You fail to maintain a minimum of [50] participants in Your Plan at any time during the Policy Year, We may elect to terminate this Policy at the end of the first month during which there are less than [50] participants.
4. This Policy will terminate at the end of the Policy Year unless agreed by You and Us to renew.
5. If You, or Your TPA, fail to satisfy any of Your obligations under this Policy, We may terminate this Policy by giving You sixty (60) days advance written notice.
6. We may terminate this Policy at the end of the Policy Year by providing you [31] days advanced written notice.
7. You may terminate this Policy at any time by providing Us with [31] days advance written notice at Our U.S. Headquarters.

The parties to this Policy may agree in writing to terminate it at any time.

Reinstatement

If this Policy is terminated for non-payment of premium, We may, at Our sole discretion, agree to reinstate it as of the date it terminated upon payment of all outstanding premiums. We may require You to provide certain information to Us before We will consider reinstating the Policy.

Time Limitations

If any time limitation in this Policy is less than that permitted by the law of the state in which the Application was taken, the limitation is hereby extended to the minimum period permitted by the law.

Section II
Benefit Provisions
[SunExcel® Centers of Excellence
Transplant Benefit

[**Introduction**

This program provides a number of benefits, which include:

- This is a voluntary program. If you utilize it, you must comply with the following terms in order to receive a benefit under it.
- Providing Covered Persons with access to Centers of Excellence Transplant Facilities;
- Reducing the Specific Benefit Deductible for a Covered Person who uses a Centers of Excellence Transplant Facility for a Transplant;
- Payment of the transplant network access fee;
- Reimbursement for travel and lodging expenses incurred by a Covered Person (and the Covered Person's parents or legal guardian(s) if the Covered Person is a minor or one companion if the Covered Person is not a minor) for the purpose of traveling to and from the Transplant, if such expenses are covered under Your Plan; and
- Reimbursement for certain expenses and deductibles paid by the Policyholder.

Definitions For the purpose of this program, the following term shall be defined as follows:

Centers of Excellence Transplant Facility: A Transplant Facility We have contracted with as part of the SunExcel® Centers of Excellence Transplant Benefit program.

Requirements

To qualify for the Transplant Benefits, You and Your Plan must satisfy all of the following requirements:

1. Your Plan must:
   a) Require precertification for Transplant related hospitalizations and outpatient Transplant procedures;
   b) Offer a minimum Transplant benefit of [$300,000];
   c) Treat Centers of Excellence Transplant Facilities as in-network providers; and

2. You must:
   a) Require Your TPA and Provider Network(s) to permit Covered Persons to access SunExcel® Centers of Excellence Transplant Facilities;
   b) Advise Your TPA and Medical Management Vendor(s) that Covered Persons may access Centers of Excellence Transplant Facilities;
   c) Agree to waive any exclusion under Your Plan that excludes expenses relating to the acquisition of an organ for a Transplant ("organ acquisition expenses"), when organ acquisition expenses are included in the global fee negotiated with a Centers of Excellence Transplant Facility; and
   d) Advise Your TPA or Medical Management Vendor to contact Our Stop Loss Case Management department at 1-800-432-1102 [x2141] when You or they receive notice that a Covered Person may require a Transplant so that We can set up the transplant contract with the Center of Excellence Transplant Facility. **In order for You to receive the benefits provide by the SunExcel Centers of Excellent Transplant Benefit, the transplant contract must be set up by Our Stop Loss Case Management department.**]

Section II
Benefit Provisions
[SunExcel® Centers of Excellence
Transplant Benefit

[SunExcel® Centers of Excellence Transplant Benefit
If You satisfy the requirements set forth above, and a Covered Person has a Transplant performed at a Centers of Excellence Transplant Facility, We will:

1. Reduce the Specific Benefit Deductible for the Covered Person by [$1,000] amount for the Policy Year in which the Transplant occurs; and

2. Pay any fee required for access to the Centers of Excellence Transplant Facility.

In addition, if Your Plan provides the following benefits as Covered Benefits under the Eligible Expenses under the SunExcel® Transplant Benefit will include:

3. Up to [$5,000] for any travel and lodging expenses incurred by the Covered Person (and the Covered Person's parents or legal guardian(s) if the Covered Person is a minor or one companion if the Covered Person is not a minor) for the purpose of traveling to and from the Transplant, if such expenses are covered under Your Plan; and/or
4. Up to [$1,500] for any deductible and co-payments waived by, or paid to, the Covered Person by Your Plan, for the year in which the Transplant occurs.]

Sun Life Assurance Company of Canada

Application for Stop-Loss Insurance

Sun Life Financial®

1 Plan Sponsor Information

Full legal name of Plan Sponsor		Policy number (office use only)
Street address		Policy effective date
City	State	Zip code

2 Subsidiaries, Affiliates, Divisions and Locations

Please list all subsidiaries, affiliates, divisions and locations to be covered under the Stop-Loss policy.

Subsidiaries, Affiliates, Divisions and Locations to be covered under this policy:

1.
2.
3.
4.
5.
6.
7.
8.

3 Requested Coverage

Please select the coverages you are applying for.

☐ **Specific Benefit**

Specific benefit deductible $	☐ Individual ☐ Family
Specific benefit lifetime maximum eligible expenses $	
☐ Aggregating Specific (if applicable)	Aggregating Specific deductible $

☐ **Aggregate Benefit**

Aggregate benefit maximum $	Aggregate benefit maximum eligible expenses per covered person* $

* Individual or family option applies to all selected coverages.

Domiciliary State - Michigan

Continued on next page

4 Proposed Benefits: Rates, Covered Lives and ADFs

Specific benefit premium rates:

Single	Family	Other
$	$	$

Specific covered benefits:

☐ Medical including Prescription Drug ☐ Medical excluding Prescription Drug

Specific covered employees:

Single	Family	Other

Aggregate benefit premium rates:

☐ Monthly rate	☐ Other: _____
$	$

Aggregate covered employees:

Single	Family	Other

Aggregate deductible factors (ADFs):

	Covered Benefit	ADF
☐	Medical	$
☐	Prescription drug plan	$
☐	Dental	$
☐	STD	$
☐	Vision	$
☐	Other _____ _____	$

☐ Monthly Aggregate Accommodation (MAA)

5 Claims Basis

Contract Basis	Specific Benefit	Aggregate Benefit
12/12 Incurred and Paid	☐	☐
15/12 3 Month Run-In	☐	☐
18/12 6 Month Run-In	☐	☐
24/12 12 Month Run-In	☐	☐
12/15 3 Month Run-Out	☐	☐
12/18 6 Month Run-Out	☐	☐
12/24 12 Month Run-Out	☐	☐
Incurred	☐	NA
Paid	NA	☐
Other _____	☐	☐
Terminal Liability Option:	☐	☐ ☐ 3 Months ☐ Other _____

Continued on next page

6 For Employers Who are Providers of Medical Services Only (i.e., hospitals)

Provide a list of Related Providers in a separate attachment.

The Related Provider Reimbursement Percentage applied to Eligible Claims Expenses for Related Provider Services will be _____ % for the Specific Benefit and _____ % for the Aggregate Benefit.

Note: Any facility, service provider, pharmacy or other vendor which is owned, operated or controlled by the Plan Sponsor, including owned divisions/subsidiaries, will be deemed a Related Provider of the Plan Sponsor.

7 Retiree Information

1. Specific Benefit: Is retiree coverage included? ..... ☐ No ☐ Yes

2. Aggregate Benefit: Is retiree coverage included? ..... ☐ No ☐ Yes

8 Additional Benefits (Must be Underwriting Approved)

These are programs and enhancements to your Stop-Loss coverage.

Clinical Trials Benefit

☐ Elect ☐ Decline

No New Special Conditions Rider (i.e., No New Lasers at Renewal)

☐ Elect ☐ Decline

9 Medical Management Vendor Information

Note: Any policy issued pursuant to this application is contingent upon the continued administration of the plan by the medical management vendors named below. If you wish to change medical management vendors, you must notify Sun Life Assurance Company of Canada at least 31 days before the effective date of the change. Our prior written agreement is required before the insurance under the Stop-Loss policy will apply to such changes. We reserve the right to recalculate any benefit provisions whenever there is a change in vendors.

List the names of all vendors that provide any form of medical management services to your plan.

Precertification/Utilization review vendor	Neo-natal management program
Case management vendor	PPO network(s)
Pregnancy management vendor	Other(s)

10 Administration Information

Provide contact information for your TPA/ASO provider for claim submissions.

Name of provider			
Provider street address	City	State	Zip code
Name of TPA/ASO claims provider contact			
TPA/ASO claims provider email address	Phone number		

Continued on next page

11 Certification and Signature

Please return this form and all additional required documentation to your Sun Life Financial Group Office.

This Application does not bind coverage. The applicant agrees to provide Sun Life Assurance Company of Canada with a current census of all eligible individuals, disclosure of all special risks on the Special Risk Questionnaire and a complete Plan document no later than the effective date specified in Section 1. Upon approval of this application, Sun Life Assurance Company of Canada will issue a Stop-Loss insurance policy with insurance coverage to become effective on the effective date. This Application will be attached to and made a part of the Stop-Loss policy.

The policy will be void if the applicant has concealed or misrepresented any material fact or circumstance concerning the subject of this application.

I have read the applicable fraud warning shown on page 5.

Name of authorized representative of Plan Sponsor	
Title	
Signature of authorized representative X	Date

Print name of Agent/Broker	
Signature of Agent/Broker X	
Florida agent/broker license ID number (required in Florida only)	Amount paid with this application $
Countersigned by licensed resident agent (when required by law) X	

Arkansas Required Notice:

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

Continued on next page

Fraud Warnings

Please read the applicable fraud warning before signing this application.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects that person to criminal and civil penalties.

Fraud Warning – CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning – District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning – FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Fraud Warning – MD: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning – OR: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may subject that person to criminal and civil penalties.

Fraud Warning – VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Fraud Warning – VA and WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
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TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Supporting Document Schedules

Satisfied -Name: Flesch Certification
Review Status: Approved-Closed 06/02/2009
Comments:
Attachment:
Flesch certification.pdf

Satisfied -Name: Application
Review Status: Approved-Closed 06/02/2009
Comments:
Attachment:
XGR-2748.pdf

Satisfied -Name: Health - Actuarial Justification
Review Status: Approved-Closed 06/02/2009
Comments:
Attachment:
Actuarial no rate impact certification.pdf

Bypassed -Name: Outline of Coverage
Review Status: Approved-Closed 06/02/2009
Bypass Reason: n/a
Comments:

CERTIFICATION

This is to certify that the Form Numbers listed below have achieved the following Flesch Reading Ease Scores and comply with the requirements of Arkansas Stat. Ann. §§66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Flesch Readability Score
07-SL-MEDTRAVEL	51.8
07-SL-CT rev.	53.4
07-SL- ELIG rev.	51.8
07-SL-LAE rev.	53.1
07-SL- CLAIM rev.	52
07-SL-GP rev.	51.5
07-SL-SUNEXCEL rev.	52.7
XGR/2748	50.7

SUN LIFE ASSURANCE COMPANY OF CANADA

Linda W. Murphy

Linda W. Murphy
Compliance Officer

May 22, 2009

Sun Life Assurance Company of Canada

Application for Stop-Loss Insurance

Sun Life Financial®

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Full legal name of Plan Sponsor		Policy number (office use only)
Street address		Policy effective date
City	State	Zip code

2 Subsidiaries, Affiliates, Divisions and Locations

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Subsidiaries, Affiliates, Divisions and Locations to be covered under this policy:

1.
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3 Requested Coverage

Please select the coverages you are applying for.

☐ **Specific Benefit**

Specific benefit deductible $	☐ Individual ☐ Family
Specific benefit lifetime maximum eligible expenses $	
☐ Aggregating Specific (if applicable)	Aggregating Specific deductible $

☐ **Aggregate Benefit**

Aggregate benefit maximum $	Aggregate benefit maximum eligible expenses per covered person* $

* Individual or family option applies to all selected coverages.

Domiciliary State - Michigan

Continued on next page

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Specific covered employees:

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Aggregate benefit premium rates:

☐ Monthly rate	☐ Other: _____
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Aggregate covered employees:

Single	Family	Other

Aggregate deductible factors (ADFs):

	Covered Benefit	ADF
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☐	Vision	$
☐	Other _____ _____	$

☐ Monthly Aggregate Accommodation (MAA)

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Paid	NA	☐
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TPA/ASO claims provider email address	Phone number		

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The policy will be void if the applicant has concealed or misrepresented any material fact or circumstance concerning the subject of this application.

I have read the applicable fraud warning shown on page 5.

Name of authorized representative of Plan Sponsor	
Title	
Signature of authorized representative X	Date

Print name of Agent/Broker	
Signature of Agent/Broker X	
Florida agent/broker license ID number (required in Florida only)	Amount paid with this application $
Countersigned by licensed resident agent (when required by law) X	

Continued on next page

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Please read the applicable fraud warning before signing this application.

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Fraud Warning – CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning – District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning – FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Fraud Warning – MD: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning – OR: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may subject that person to criminal and civil penalties.

Fraud Warning – VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Fraud Warning – VA and WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Actuarial Certification

Sun Life Assurance Company of Canada

RE: Forms: 07-SL-MEDTRAVEL et al.

I hereby certify that there is no impact of the above forms on any manual rates currently on file with your Department. Additionally, I certify that the benefits are reasonable in relation to the premium charged.

Paula Jones, F.S.A., M.A.A.A.

Director, Stop Loss Actuarial

May 13, 2009
Date

SERFF Tracking Number:	*SNLF-126122890*	*State:*	*Arkansas*
Filing Company:	*Sun Life Assurance Company of Canada*	*State Tracking Number:*	*42459*
Company Tracking Number:	*2009 CONTRACT REVISIONS*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*Group Stop Loss*		
Project Name/Number:	*2009 Contract Revisions/*		

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Group Application	05/22/2009	XGR-2748.pdf

Sun Life Assurance Company of Canada

Application for Stop-Loss Insurance

Sun Life Financial®

1 Plan Sponsor Information

Full legal name of Plan Sponsor		Policy number (office use only)
Street address		Policy effective date
City	State	Zip code

2 Subsidiaries, Affiliates, Divisions and Locations

Please list all subsidiaries, affiliates, divisions and locations to be covered under the Stop-Loss policy.

Subsidiaries, Affiliates, Divisions and Locations to be covered under this policy:

1.
2.
3.
4.
5.
6.
7.
8.

3 Requested Coverage

Please select the coverages you are applying for.

☐ **Specific Benefit**

Specific benefit deductible $	☐ Individual ☐ Family
Specific benefit lifetime maximum eligible expenses $	
☐ Aggregating Specific (if applicable)	Aggregating Specific deductible $

☐ **Aggregate Benefit**

Aggregate benefit maximum $	Aggregate benefit maximum eligible expenses per covered person* $

* Individual or family option applies to all selected coverages.

Domiciliary State - Michigan

Continued on next page

4 Proposed Benefits: Rates, Covered Lives and ADFs

Specific benefit premium rates:

Single	Family	Other
$	$	$

Specific covered benefits:

☐ Medical including Prescription Drug ☐ Medical excluding Prescription Drug

Specific covered employees:

Single	Family	Other

Aggregate benefit premium rates:

☐ Monthly rate	☐ Other: _____
$	$

Aggregate covered employees:

Single	Family	Other

Aggregate deductible factors (ADFs):

	Covered Benefit	ADF
☐	Medical	$
☐	Prescription drug plan	$
☐	Dental	$
☐	STD	$
☐	Vision	$
☐	Other _____ _____	$

☐ Monthly Aggregate Accommodation (MAA)

5 Claims Basis

Contract Basis	Specific Benefit	Aggregate Benefit
12/12 Incurred and Paid	☐	☐
15/12 3 Month Run-In	☐	☐
18/12 6 Month Run-In	☐	☐
24/12 12 Month Run-In	☐	☐
12/15 3 Month Run-Out	☐	☐
12/18 6 Month Run-Out	☐	☐
12/24 12 Month Run-Out	☐	☐
Incurred	☐	NA
Paid	NA	☐
Other _____	☐	☐
Terminal Liability Option:	☐	☐ ☐ 3 Months ☐ Other _____

Continued on next page

6 For Employers Who are Providers of Medical Services Only (i.e., hospitals)

Provide a list of Related Providers in a separate attachment.

The Related Provider Reimbursement Percentage applied to Eligible Claims Expenses for Related Provider Services will be _____ % for the Specific Benefit and _____ % for the Aggregate Benefit.

Note: Any facility, service provider, pharmacy or other vendor which is owned, operated or controlled by the Plan Sponsor, including owned divisions/subsidiaries, will be deemed a Related Provider of the Plan Sponsor.

7 Retiree Information

1. Specific Benefit: Is retiree coverage included? ..... ☐ No ☐ Yes

2. Aggregate Benefit: Is retiree coverage included? ..... ☐ No ☐ Yes

8 Additional Benefits (Must be Underwriting Approved)

These are programs and enhancements to your Stop-Loss coverage.

Clinical Trials Benefit

☐ Elect ☐ Decline

No New Special Conditions Rider (i.e., No New Lasers at Renewal)

☐ Elect ☐ Decline

9 Medical Management Vendor Information

Note: Any policy issued pursuant to this application is contingent upon the continued administration of the plan by the medical management vendors named below. If you wish to change medical management vendors, you must notify Sun Life Assurance Company of Canada at least 31 days before the effective date of the change. Our prior written agreement is required before the insurance under the Stop-Loss policy will apply to such changes. We reserve the right to recalculate any benefit provisions whenever there is a change in vendors.

List the names of all vendors that provide any form of medical management services to your plan.

Precertification/Utilization review vendor	Neo-natal management program
Case management vendor	PPO network(s)
Pregnancy management vendor	Other(s)

10 Administration Information

Provide contact information for your TPA/ASO provider for claim submissions.

Name of provider			
Provider street address	City	State	Zip code
Name of TPA/ASO claims provider contact			
TPA/ASO claims provider email address	Phone number		

Continued on next page

11 Certification and Signature

Please return this form and all additional required documentation to your Sun Life Financial Group Office.

This Application does not bind coverage. The applicant agrees to provide Sun Life Assurance Company of Canada with a current census of all eligible individuals, disclosure of all special risks on the Special Risk Questionnaire and a complete Plan document no later than the effective date specified in Section 1. Upon approval of this application, Sun Life Assurance Company of Canada will issue a Stop-Loss insurance policy with insurance coverage to become effective on the effective date. This Application will be attached to and made a part of the Stop-Loss policy.

The policy will be void if the applicant has concealed or misrepresented any material fact or circumstance concerning the subject of this application.

I have read the applicable fraud warning shown on page 5.

Name of authorized representative of Plan Sponsor	
Title	
Signature of authorized representative X	Date

Print name of Agent/Broker	
Signature of Agent/Broker X	
Florida agent/broker license ID number (required in Florida only)	Amount paid with this application $
Countersigned by licensed resident agent (when required by law) X	

Continued on next page

Fraud Warnings

Please read the applicable fraud warning before signing this application.

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects that person to criminal and civil penalties.

Fraud Warning – CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Warning – District of Columbia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning – FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Fraud Warning – MD: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning – OR: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may subject that person to criminal and civil penalties.

Fraud Warning – VT: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Fraud Warning – VA and WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.